

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the addition of
date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (982)

10173

FILE No. G 99 NOV 1 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County... Howard

City or town... Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard

City or town... Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Josephine Boldison

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife James O. Boldison

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

August 20, 1884

8. AGE:

Years

Months

Days

If less than one day

61

1

26

hrs.

min.

9. Birthplace

Ellicott City, Md.
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

George Clark

13. Birthplace

Md.

MOTHER

14. Maiden name

Elyia McKeuzie

15. Birthplace

Md.

16. Informant

James O. Boldison
Address Ellicott City, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

10-19-45
(month) (day) (year)

Cemetery or crematory

St. Johns

Location

Ellicott City, Md.

18. Funeral director

J.C. McKeuzie

Address

Ellicott City, Md.

19.

Oct. 13, 1945
(Date rec'd by registrar)

John B. Longman
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1945, at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 13, 1945, to Oct. 16, 1945

and that I last saw him alive on Oct. 16, 1945

Immediate cause of death

Hypertension - Cerebrovascular disease

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leon A. Kochman M.D.

M. D. or other

Address Ellicott City, Md. Date signed 10/16/45

RECEIVED
OCT 22 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1540

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County Howard
 City or town Ellicott City, H. F. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs.
 Hospital, institution, or street address where death occurred:
Guilford Road, Pfeiffers Corner
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Ellicott City, R. F. D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Guilford Road, Pfeiffers Corner
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jodie Catherine Boritz

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Morris Michael Boritz
 6.(c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) March 5, 1893
 8. AGE: Years 52 Months 7 Days 20 It less than one day _____ hrs. _____ min.

9. Birthplace Kline, Grant, W. Virginia
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Alie Klesner13. Birthplace West Virginia14. Maiden name Unknown15. Birthplace Unknown16. Informant Morris BoritzAddress Ellicott City, R. F. D.17. Burial Date thereof Oct. 28, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's LutheranLocation Howard County, Maryland18. Funeral director Carlton GossAddress Ellicott City, Maryland19. 10/26/45 Frank Shipley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25th 19 45, at 8a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 23rd 19 45 to Oct. 25th 19 45 and that I last saw him alive on Oct. 24th 19 45

Immediate cause of death

Pulmonary Embolism

DURATION

2 daysDue to Chr. Osteomyelitis of
rt. tibia2 yrs.Other conditions ☒

(Include pregnancy within 8 months of death)

Major findings of operations ☒

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Frank Shipley, M.D.
Savage, Md. M. D. or other
Date signed 10/26/45

RECEIVED
OCT 31 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:

County... Howard
 City or town... Elbridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard
 City or town... Elbridge 27
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 5503 Main St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Newton Earp

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife 6. (c) If alive, give age 73 years

Annie D. Earp

7. Birth date of deceased (mo., day, yr.) June 9, 1860

8. AGE: Years 85 Months 4 Days 19 If less than one day hrs. min.

9. Birthplace Rockburn, Ind.
(Town, county, and state)

10. Usual occupation Retired Postal Clerk

11. Industry or business

12. Name James W. Earp

13. Birthplace Laurel, Md.

14. Maiden name Catherine Weaver

15. Birthplace Elbridge Md.

16. Informant S. Lester Earp

Address 5503 Main St. Elbridge Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1945 (month) (day) (year)

Cemetery or crematory Melville Cemetery

Location Elbridge, Ind.

18. Funeral director S. Lester Earp

Address Elbridge Md.

19. Oct. 31 1945 (Date rec'd by registrar)

(Date rec'd by registrar)

20. DATE OF DEATH Oct 28 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 45 to Oct 28 1945 and that I last saw him alive on Oct 28 1945

Immediate cause of death acute coronary atherosclerosis

Due to myocardial infarction

Due to Rt. Hemiplegia

Other conditions coronary artery disease

(Include pregnancy within 6 months of death)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 45 to Oct 28 1945 and that I last saw him alive on Oct 28 1945

Immediate cause of death acute coronary atherosclerosis

Due to myocardial infarction

Due to Rt. Hemiplegia

Other conditions coronary artery disease

(Include pregnancy within 6 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Lester Earp

Address 5609 Main St. Elbridge Md.

M. D. or other

Data signed 10/30/45

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF CRIMES

RECEIVED

NOV 2 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-1

CERTIFICATE OF DEATH

10176

Reg. Dist. No. 190

1. PLACE OF DEATH:

County HowardCity or town Edbridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Edbridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2011 Furnace Ave.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Clara E. Grimm

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, or divorced

married6. (b) Name of husband or wife George H. Grimm

7. Birth date of

deceased (mo., day, yr.) May 7, 1885

8. AGE: Years Months Days If less than one day

6056hrs.min.9. Birthplace Baltimore MD

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Milton Griffin13. Birthplace Maryland14. Maiden name E. Elizabeth15. Birthplace Maryland16. Informant Ms. George H. GrimmAddress 2011 Furnace Ave17. Burial Date thereof 10-16-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory WesternLocation Balto. MD18. Funeral director Harry H. WitkeAddress 4101 Edmondson Ave19. Oct. 16 19 45 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 45 at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 45 to Oct 13 19 45and that I last saw him alive on Oct 13 19 45Immediate cause of death Carcinoma DURATIONof right lung + 1 1/2of 1st + 2nd + 3rd + 4th + 5thDue to Myocardialinfarction 2 moDue to plasma poisoning

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations carcinoma bythorax fluid from stage Date of op. Oct. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. P. Brumby M. D. or otherAddress 1609 Gann St Date signed 10/13/45

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

1. NAME OF DECEASED

ADDITIONAL INFORMATION

RECEIVED
OCT 17 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-3)

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County HowardCity or town Gorman Rd. near Savage
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 76 years

Hospital, institution, or street address where death occurred:

near - Savage

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Gorman Rd.
(If outside city or town limits, write RURAL and give nearest town)Street No. Heat Savage Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Fletcher Hearn

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sadie A. Hearn

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1869

8. AGE: Years Months Days If less than one day

76 8 29 hrs. min.9. Birthplace Dayton Howard Co. Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Samuel Close Hearn13. Birthplace Glenwood, Md.14. Maiden name Maxia C. Miller15. Birthplace Baltimore, Md.16. Informant Mrs. Sadie A. HearnAddress Gorman Rd. Laurel P.O.17. Burial Date thereof Nov. 1, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Zion CemeteryLocation Highland 3 Howard Co. Md18. Funeral director E. Astor RossAddress Ellicott City Md19. 10/31/45 19 Shank Shipley
(Date rec'd by registrar) (Year) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 29 1945, at 7 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 23 1945, to 10 29 1945and that I last saw him alive on 10 29 1945Immediate cause of death Acute Cardiacinfarction

DURATION

Due to chr. myocarditis 5 yrsDue to chr. nephritis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B P Warner M. D. or otherAddress Laurel Md Date signed 10-30-45

RECEIVED

NOV 2 1945

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1173

10178 e

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

County Pine Clinic Ellicott Md
City or town Ellicott City Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Ellicott City Md

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard
City or town Ellicott City Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

HARRY HORWITZ

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business None

FATHER 12. Name John Horwitz

13. Birthplace Russia

MOTHER 14. Maiden name Dora Shull

15. Birthplace Russia

16. Informant Mrs Sarah Leavey

Address 4618 Pimlico Road

17. Burial Date thereof October 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hebrew Washington Road Cem

Location Washington Blvd

18. Funeral director Sol Levinson & Bros

Address 1124-1126 W North Ave

19. 10-10-45 Registrar Edw. J. Kerman
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 19 45, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 19 45, to Oct. 9 19 45, and that I last saw him alive on Oct. 9 19 45.

Immediate cause of death Gastric hemorrhage

Due to chronic gastritis

Due to _____

Other conditions Insanition
Anorexia Nervosa
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edward J. Kerman M. D. or other _____

Address 2338 Centaw Place Bx Date signed 10-9-45

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 463

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
6623 Old Washington Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6623 Old Washington Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

STEFANIA LENCZYCKA

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Benjamin Lenczycki

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) December ? 1899

8. AGE: Years Months Days If less than one day
45 10 hrs. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Teofil Danielak

13. Birthplace Poland

14. Maiden name Sophie -----

15. Birthplace Poland

16. Informant Mr. Benjamin Lenczycki

Address 6623 Old Washington Blvd.

17. Burial Date thereof October 17, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Rosary

Location German Hill Road

18. Funeral director M. J. Sadowski & Son

Address 1808 Eastern Avenue

19. 10/16 19 45 A. W. Madrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 45 at 12 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 42, to Oct 13 19 45, and that I last saw him alive on Oct 13 19 45.

Immediate cause of death Carcinoma of the stomach
metastasis active
Due to myocardial infarction
Due to 3 no

Other conditions Banti's Disease
(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of the stomach
Date of op. Apr 1944

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
Address 5609 Main St Date signed 10/13/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

CERTIFICATE OF DEATH

Reg. Dist. No. 10180 190

1. PLACE OF DEATH:

County HowardCity or town Hammer
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 34 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Hammer
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Agnes Theresa A. Lerp.

3. (b) Social Security Number

none4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Walter A. Lerp.7. Birth date of deceased (mo., day, yr.) Nov 1 - 1876 6.(c) If alive, give age _____ years8. AGE: Years 68 Months 11 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore City, Md
(Town, county, and state)10. Usual occupation domestic

11. Industry or business _____

12. Name Rudolph13. Birthplace Baltimore Md14. Maiden name unknown

15. Birthplace _____

16. Informant Mr. Rudolph Lerp (son)Address Hammer Md17. Burial Date thereof Oct 27 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Baltimore Md18. Funeral director S. Lester LerpAddress Elkridge Md19. Oct. 25 19 45 (Date rec'd by Registrar) (month) (day) (year)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 19 45 at 1:55 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 44 to Oct 25 19 45and that I last saw him alive on Oct 20 19 45Immediate cause of death acute coronary

DURATION

2 daysocclusionDue to Chr Myocarditis 1940Due to San Antonio feverOther conditions sepsis

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. B. Cunningham M. D. or otherAddress 1809 main St Elkridge Md Date signed 10/26/45

CERTIFICATE OF DEATH

RECEIVED
OCT 26 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 10184

1. PLACE OF DEATH: County..... <u>Howard</u> City or town..... <u>Columbia Rd. Ellicott City</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>65 yrs</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Howard</u> City or town..... <u>Ellicott City</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Columbia Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Richard Baker Owings</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>10 - 26</u> ..19.. <u>45</u> ..at.. <u>7 A.</u> M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>10/26</u> ..19.. <u>45</u> ..to.. <u>10/26</u> ..19.. <u>45</u> and that I last saw h... alive on .. <u>no date</u> ..19.. Immediate cause of death <u>Coronary Thrombosis</u> Due to..... <u>Arteriosclerotic vascular disease</u> Due to..... Other conditions..... <u>none</u> (Include pregnancy within 3 months of death) Major findings of operations <u>none</u> Date of op. Autopsy results <u>none</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?.....	
6. (b) Name of husband or wife <u>Alice W. Owings</u>		6. (c) If alive, give age <u>43</u> ..years					
7. Birth date of deceased (mo., day, yr.) <u>June 1st, 1880</u>		8. AGE: Years..... <u>65</u> Months..... <u>4</u> Days..... <u>25</u>hrs.min.					
9. Birthplace <u>Howard Co. Maryland</u> (Town, county, and state)		10. Usual occupation <u>Farmer</u>					
11. Industry or business <u>Own farm</u>		12. Name <u>John H. Owings</u>		13. Birthplace <u>Howard Co. Md.</u>		14. Maiden name <u>Sally Ann Dorsey</u>	
15. Birthplace <u>Howard Co. Md.</u>		16. Informant <u>Mrs. Alice W. Owings</u> Address..... <u>Simpsonville Md.</u>		17. Burial <u>St. Johns Cemetery</u> (Burial, cremation, or removal. Which?) Date thereof..... <u>Oct. 28, 1945</u> (month) (day) (year) Cemetery or crematory..... Location..... <u>Ellicott City, Md.</u>		18. Funeral director <u>Easton Sons</u> Address..... <u>Ellicott City, Md.</u>	
19. (Date rec'd by registrar) <u>Oct. 27, 1945</u> <u>John B. Loughman</u> (Date rec'd by registrar) Registrar		23. SIGNATURE <u>George E. Burgtorf M.D.</u> DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other Address..... <u>Ellicott City, Md.</u> Date signed..... <u>10/26/45</u>					

RECEIVED
OCT 30 1965
BUREAU V & E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1866

CERTIFICATE OF DEATH



Reg. Dist. No. 74

1. PLACE OF DEATH:

County HowardCity or town Eldridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John L. Richardson

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Mary E. Richardson

7. Birth date of deceased (mo., day, yr.)

April 29, 18816. (c) If alive, give age. ✓ years

8. AGE:

Years

Months

Days

If less than one day

6453

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

State Parks Commission

MOTHER FATHER

12. Name

John L. Richardson

13. Birthplace

Md.

14. Maiden name

Annie Gillies

15. Birthplace

Md.

16. Informant

Mrs. Mary E. Richardson

Address

Eldridge, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 5, 1945
(month), (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

New Windsor, Carroll Co., Md.

18. Funeral director

C. Harry Evers

Address

Eldridge, Md.19. Oct 3

(Date rec'd by registrar)

19 45C. Harry Evers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Carroll

City or town

Eldridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-2

19

45

at

2:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-2

19

45

to

10-2

19

45

and that I last saw him alive on

no date

19

Immediate cause of death

fractured Pelvis with internal injuries

Due to

crushed under falling wall

Due to

Other conditions

multiple contusionsfracture left tibia
(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

10/2/45

Where did injury occur?

Eldridge

(City or town)

Howard

(County)

Md.

(State)

Injured at home, farm, industry, public place (where?)

Public highway

Means of injury

struck by falling wallInjured at work? yes

23. SIGNATURE

George E. BaugherM.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

M. D. or other

Address

Eldridge, Md.

Date signed

10/2/45

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OCT 9 1915
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 101884

1. PLACE OF DEATH:

County HowardCity or town Dayton, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 77 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Dayton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella May Scrivnor

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife William J. Scrivnor6. (c) If alive, give age 87 years

7. Birth date of

deceased (mo., day, yr.) Aug. 5, 1868

8. AGE:

Years

Months

Days

If less than one day

77210

hrs.

min.

9. Birthplace Dayton, Howard Co., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name

B. A. Nichols

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Jane Hearn

15. Birthplace

Maryland16. Informant William J. Scrivnor

Address

Dayton, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof Oct. 18, 1945
(month) (day) (year)

Cemetery or crematory

St. Marks Cemetery

Location

Highland, Md.

19. Funeral director

Easton Sons

Address

Ellicott City, Md.19. Oct. 16
(Date rec'd by registrar)19. NovS. A. Nichols
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 19 45 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19 45 to Oct. 15 19 45
and that I last saw her alive on Oct. 15 19 45

Immediate cause of death

Central hemorrhage

DURATION

15 min.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

S. A. Nichols
M. D. or other
Address Clarksville Date signed Oct. 17

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 10184 194

1. PLACE OF DEATH:

County..... Howard
 City or town..... Glenely
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Howard
 City or town..... Glenely
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles Alexander Warfield

3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... Widower

6. (b) Name of husband or wife..... Rachel Dorsey Warfield

7. Birth date of deceased (mo., day, yr.)..... Feb. 1, 1876 6. (c) If alive, give age..... years

8. AGE: Years..... 69 Months..... 9 Days..... 2 If less than one day..... hrs. min.

9. Birthplace..... Maryland
(Town, county, and state)10. Usual occupation..... Farmer

11. Industry or business.....

12. Name..... Thos. O. Warfield
 13. Birthplace..... md

14. Maiden name..... Laura Dorsey
 15. Birthplace..... md

18. Informant..... Howard W. Clark
 Address..... Glenely, md

17. Burial Date thereof..... 11-2-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oak Grove Cem.
 Location..... Glenely, md

18. Funeral director..... F.C. Hey, whothorn
 Address..... Emmett City, md

19. 11-1 19 45 L.P. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 10/31/45 at 2 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/28/45 to 10/31/45 and that I last saw him/her on 10/31/45.

Immediate cause of death..... Cardiovascular disease DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H.A. Barnes MD M. D. or other

Address..... Ly Knolls MD Date signed..... 10/31/45

RECEIVED
NOV 5 1945
BUREAU